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Health Care Benefit for Women Comparable to Other Plans



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Abstract <p>About half of all beneficiaries who are eligible to use TRICARE, the Department of Defense (DOD) health care program, are women—neither active duty personnel, family members, or retirees. With a health care system historically oriented towards men, DOD has been challenged to ensure that its women beneficiaries receive the full range of services including primary, specialty, preventive, and reproductive care. The National Defense Authorization Act (NDAA) for fiscal year 2002 directed that we study the adequacy and quality of the health care provided to women by DOD. As agreed with the committees of jurisdiction, we will describe (1) the health care benefit targeted to women covered under the TRICARE program and how this benefit compares to national clinical guidelines and other health plans offerings and (2) women beneficiaries satisfaction with and concerns about DOD's health care benefit.</p>				
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Abbreviations

ACOG	American College of Obstetricians and Gynecologists
CHPPM	Center for Health Promotion and Preventive Medicine
DACOWITS	Defense Advisory Committee on Women in the Services
DES	diethylstilbestrol
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
HMO	health maintenance organization
MTF	military treatment facility
NDAA	National Defense Authorization Act
NMFA	National Military Family Association
PCM	primary care manager
REACH	Recruit Education to Achieve Health
SHARP	Sexual Health and Responsibility Program
TMA	TRICARE Management Activity
TPR	TRICARE Prime Remote



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Congressional Committees

About half of all beneficiaries who are eligible to use TRICARE, the Department of Defense's (DOD) health care program, are women—either active duty personnel, family members, or retirees. With a health care system historically oriented towards men, DOD has been challenged to ensure that its women beneficiaries receive the full range of services including primary, specialty, preventive, and reproductive care. The National Defense Authorization Act (NDAA) for fiscal year 2002 directed that we study the adequacy and quality of the health care provided to women by DOD. As agreed with the committees of jurisdiction, we will describe (1) the health care benefit targeted to women covered under the TRICARE program and how this benefit compares to national clinical guidelines and other health plans' offerings and (2) women beneficiaries' satisfaction with and concerns about DOD's health care benefit.

To conduct our work, we reviewed relevant policies and procedures and interviewed officials from DOD's Health Affairs' Office of Clinical and Program Policy; DOD's TRICARE Management Activity (TMA); and the Surgeons General Offices for the Air Force, Army, and Navy. We also interviewed officials from the American College of Obstetricians and Gynecologists (ACOG)¹ and reviewed two of the largest health care plans under the Federal Employees Health Benefits Program (FEHBP)² to compare the covered benefits with TRICARE's. To determine beneficiaries' perceptions on women's health care services in TRICARE, we relied on our past work on DOD health care, and we reviewed the latest available data from two DOD surveys: a DOD-wide health care survey on beneficiary satisfaction and a survey targeted at inpatient care during childbirth at selected military treatment facilities (MTF). In addition, we held interviews with the Defense Advisory Committee on Women in the Services (DACOWITS), a group that advises the Secretary of Defense on issues concerning active duty women, and the National Military Family

¹ACOG is a national organization that develops guidelines for clinical practice for women's health care services.

²The FEHBP, administered by the Office of Personnel Management, is the largest employer-sponsored group health insurance program in the world. FEHBP offers fee-for-service plans with preferred provider organizations, health maintenance organization (HMO) plans, and plans offering a point-of-service product.

Association (NMFA), an advocacy group that obtains beneficiary views on issues concerning military families. However, we did not independently validate this information or determine the prevalence of beneficiary concerns. It should also be noted that while our review focuses on health care for women beneficiaries, a number of our findings pertain to men as well, which we note where appropriate. Our work was conducted from November 2001 through April 2002 in accordance with generally accepted government auditing standards. (For more on our scope and methodology, see app. I.)

Results in Brief

TRICARE offers a full range of health care services for women beneficiaries, including obstetrical and gynecological care and diagnostic services such as Papanicolaou (Pap) smears and mammograms. The TRICARE benefits package is uniform across all three branches of the military and for all beneficiary types—active duty personnel, family members, and retirees. The TRICARE covered benefits are in line with ACOG guidelines and are comparable to women’s health benefits offered by two of the largest health plans under FEHBP. In addition, DOD—like the FEHBP plans we reviewed—requires some beneficiaries to share in the cost of their health care. Both DOD’s and FEHBP’s copayments, which are the same for men and women, vary depending on the plan option and providers selected.³

DOD’s women beneficiaries, overall, report being satisfied with the health care benefit they receive under TRICARE. For example, the average rating from women for the health care they received was 7.8 on a scale where 10 represents the best health care possible—the same rating as given by men. Some of DOD’s women beneficiaries, however, have expressed concerns about obtaining the services available to them. Generally, these concerns stem from where the beneficiary is located—especially those stationed overseas or in remote areas—and beneficiaries’ expectations about the providers, sources of care, and supplies available to them. For example, in overseas locations, DOD beneficiaries may face medical practice, language, and cultural differences with host nation care that can make them reluctant to seek care. DOD officials told us that for active duty women, concerns also stem from the attitudes and the climate established by the command personnel who may not understand women’s health care needs. DOD

³Active duty personnel and their family members who are enrolled in TRICARE Prime—DOD’s HMO option—do not have copayments.

officials also told us that some commanders may be reluctant to allow active duty members—both men and women—time away from their duty stations to obtain health care services. In commenting on a draft of our report, DOD agreed with our findings.

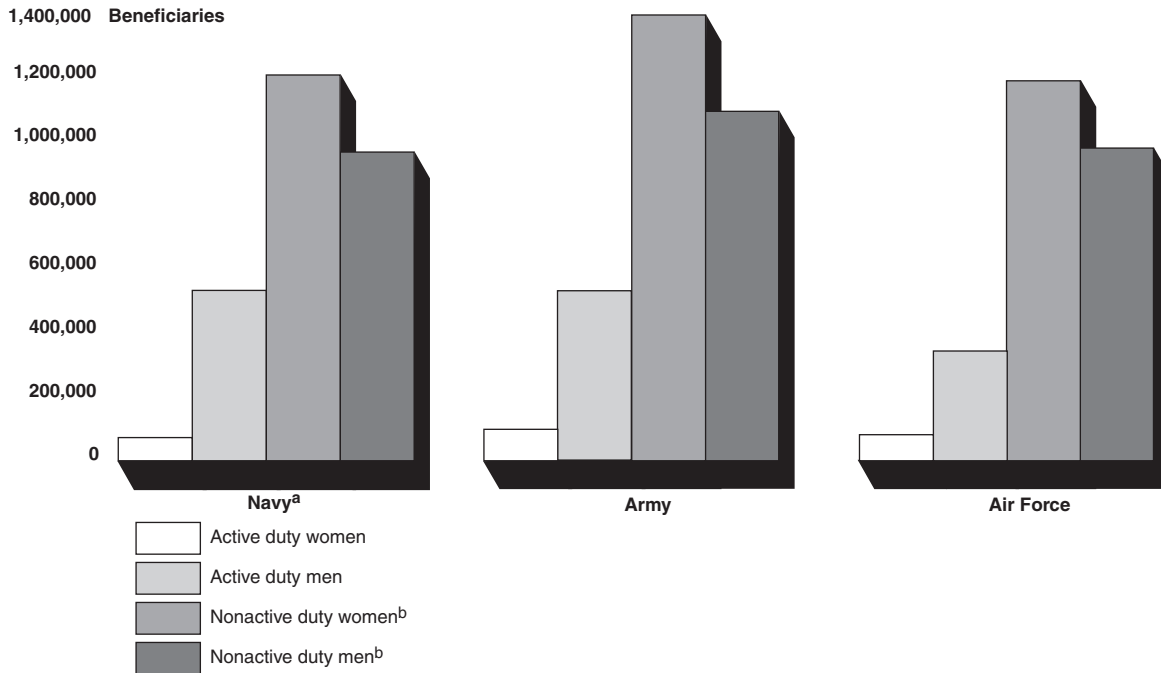
Background

DOD's medical mission includes maintaining the health of 1.7 million active duty personnel⁴ and providing health care to them during military operations. About 12 percent of the Navy's active duty personnel,⁵ about 16 percent of the Army's active duty personnel, and about 19 percent of the Air Force's active duty personnel are women. DOD also offers health care to women who are family members of active duty personnel, retirees, family members of retirees, and survivors of active duty and retired active duty members (see fig.1).

⁴Includes members of the Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service. It also includes National Guard members who are eligible for care in the military health system when they are in active duty status.

⁵The calculation of the percent of women active duty personnel in the Navy includes active duty personnel in the Marine Corps.

Figure 1: Men and Women Active Duty and Nonactive Duty Beneficiaries by Branch of the Military, as of April 1, 2002



^aThe number of Navy beneficiaries includes beneficiaries in the Marine Corps.

^bNonactive duty beneficiaries include family members of active duty personnel, retirees, family members of retirees, and survivors of active duty and retired active duty members.

Source: DOD.

DOD beneficiaries are provided benefits through one of three health plans: TRICARE Prime (an HMO option), TRICARE Extra (a preferred provider option), and TRICARE Standard (a fee-for-service option). Active duty members are required to enroll in TRICARE Prime, but family members and retirees under age 65 can choose among any of the three plans. DOD

also provides benefits to military beneficiaries who are Medicare-eligible.⁶ Beneficiary copayments vary depending on the TRICARE option. Active duty personnel and their family members who are enrolled in TRICARE Prime do not have copayments.

Under TRICARE, health care is provided in MTFs worldwide and by civilian providers. Priority for care at MTFs varies depending on the beneficiary type—active duty, family member, or retiree—and the TRICARE option. Active duty members have the highest priority for care at MTFs, followed by other beneficiaries enrolled in TRICARE Prime.⁷ Beneficiaries who are eligible for military health care, but not enrolled in TRICARE Prime, may receive care at MTFs on a space-available basis. Active duty members are required to use MTF care, if available. Family members and retirees may obtain care at either military or civilian facilities, depending on the TRICARE plan they choose.

Policy regarding health care for all DOD beneficiaries is developed by the Office of the Assistant Secretary of Defense for Health Affairs (Health Affairs). TMA oversees the operation of the TRICARE Program. Health Affairs and TMA coordinate with the Air Force, Army, and Navy to implement TRICARE, but the Surgeon General of each branch of the military has authority over its own MTFs. TMA also oversees the TRICARE contracts with the civilian providers.

⁶Medicare is a federally financed health insurance program that covers health care expenses of the elderly, some people with disabilities, and people with end-stage kidney disease. Military retirees aged 65 or older are eligible for Medicare on the same basis as civilian retirees. In 2001, military retirees enrolled in Medicare part B (which covers physician care, other outpatient services, and selected home health services) became eligible for TRICARE coverage—commonly called TRICARE for Life. As a result, TRICARE is now a secondary payer for these retirees' Medicare-covered services—paying most of the required cost sharing. Retirees can also obtain services at MTFs, but when they do this, DOD does not receive payments from Medicare for those services it provides them.

⁷Beneficiaries enrolled in TRICARE Plus—a new MTF primary care enrollment program offered at selected MTFs—also receive primary care appointments with the same access standards as TRICARE Prime enrollees.

DOD and the three branches of the military have implemented policies and initiatives specifically aimed at improving the delivery of health services for women. (See app. II for details.) For example, a 1998 DOD policy states that women enrolled in TRICARE Prime shall have the option to choose a primary care manager (PCM)⁸ who has advanced training in women's health issues.⁹ Additionally, MTFs have begun providing "family-centered" obstetrical care by involving the family in the continuum of care from prenatal through postpartum. Other efforts have been aimed at educating line commanders and beneficiaries about the importance of women's health care services to readiness.

DOD's Health Care Benefit for Women is Comparable to Other Plans

DOD offers a full range of health care services for women beneficiaries through the TRICARE benefit. In general, TRICARE-covered benefits for women reflect national clinical guidelines developed by ACOG and are comparable to widely used FEHBP health plans. DOD—like the FEHBP plans we reviewed—requires some beneficiaries to share in the cost of their health care. These copayments, which are the same for men and women, vary depending on the plan option and providers selected.

DOD Health Care Services for Women

In addition to the range of health care services offered to all DOD beneficiaries, TRICARE provides health care services targeted specifically to women. The benefit is uniform across all three branches of the military, and generally for all beneficiary types, including active duty members, family members, and retirees. These services include the following primary, specialty, preventive, and reproductive care.

⁸A PCM coordinates enrollees' care and refers them to the appropriate specialists, if needed.

⁹According to DOD officials, the availability of PCMs with advanced training in women's health care may be limited.

-
- Comprehensive obstetrical and gynecological care, including care related to pregnancy and family planning, and screening for gynecological cancers:
 - prenatal, maternity, and postpartum care, including HIV and Hepatitis B screening for pregnant women, and genetic testing when medically indicated to determine if an unborn child has genetic defects,¹⁰ and
 - family planning, including contraceptives, diagnosis and treatment of infertility, and sterilization;
 - pelvic exams and Pap smears;
 - breast examinations and mammography;
 - breast reconstructive surgery for mastectomy patients and other breast surgery;¹¹
 - hormone replacement therapy and counseling regarding the benefits and risks of hormone replacement therapy for menopausal women; and
 - bone density studies to diagnose and monitor osteoporosis, osteopenia, and for those at high-risk of bone disease.

TRICARE Health Benefits for Women Are In Line With National Guidelines and Other Health Plans

The TRICARE benefit is consistent with the guidelines for women's health issued by ACOG for primary, specialty, preventive, and reproductive care. TRICARE benefits are also comparable to the range of benefits for women offered under two FEHBP health plans—BlueCross and BlueShield Service Benefit Plans (BlueCross BlueShield), a fee-for-service and preferred provider plan with the largest number of participants in FEHBP; and Kaiser

¹⁰TRICARE covers genetic testing if the mother is aged 35 or older or had rubella during the first 3 months of pregnancy, or has a family history of genetic defects.

¹¹TRICARE covers cosmetic, reconstructive, and plastic surgery for breasts in the following cases: (1) correction of a congenital anomaly, (2) restoration of body form (including revision of scars) following an accidental injury, (3) revision of disfiguring and extensive scars resulting from neoplastic surgery, and (4) reconstructive breast surgery following a medically necessary mastectomy performed for the treatment of carcinoma, severe fibrocystic disease, other nonmalignant tumors, or traumatic injuries.

Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser), one of the FEHBP's largest HMO plans. Specifically, BlueCross BlueShield and Kaiser also offer the full range of women's health care services covered by TRICARE as listed above, including obstetrical and gynecological care, maternity care, family planning, mammography, reconstructive breast surgery, hormone therapy, and bone density studies. For example, TRICARE coverage for Pap smears and mammograms is in line with the FEHBP plans that we reviewed as well as with ACOG guidelines that call for screenings based on age and risk. (See table 1.)

Table 1: Comparison of TRICARE Pap Smear and Mammogram Standards With ACOG Guidelines and Other Plan Standards

ACOG	TRICARE	FEHBP HMO (Kaiser)	FEHBP Fee-for-service (BlueCross BlueShield)
Pap smear			
Preventive care includes a routine Pap smear annually when sexually active or at age 18. For patients age 19 and above, physician and patient discretion is recommended after three consecutive normal tests, if low risk. ^a	Preventive care includes a routine Pap smear annually at age 18 (or younger, if sexually active) until three normal tests. After three normal tests, then test frequency is a physician and patient decision, but not less than every three years.	Preventive care includes a routine Pap smear. Regarding test frequency, members are advised to consult with physician to determine what is appropriate.	Preventive care includes a routine Pap smear annually for women of any age.
Mammogram			
Preventive care includes a routine mammogram for women as follows: <ul style="list-style-type: none"> • Age 19 to 39: periodic assessment, if high risk^b • Age 40 to 49: 1 test every 1 to 2 years • Age 50 to 64: yearly • Age 65 and above: periodic assessment. 	Preventive care includes a routine mammogram for women as follows: <ul style="list-style-type: none"> • Age 40 and below: 1 baseline test • Age 41 to 50: 1 test every 2 years • Age 50 and above: yearly. 	Preventive care includes a routine mammogram for women as follows: <ul style="list-style-type: none"> • Age 35 to 39: 1 baseline test • Age 40 to 64: 1 test every calendar year • Age 65 and above: 1 test every 2 consecutive calendar years. 	Preventive care includes a routine mammogram for women as follows: <ul style="list-style-type: none"> • Age 35 to 39: 1 baseline test • Age 40 to 64: 1 test annually • Age 65 and above: 1 test every 2 consecutive calendar years.

^aACOG recommends more frequent Pap tests when one or more high risk factors is present, for example, women who have had multiple sexual partners and women with a history of sexually transmitted diseases.

^bFor mammograms, high risk is defined as women who have had breast cancer or have a first-degree relative (that is, mother, sister, or daughter) or multiple other relatives who have a history of premenopausal breast, or breast and ovarian, cancer.

Sources: ACOG guidelines effective in 2002, DOD TRICARE benefit for 2002, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for 2002, and BlueCross BlueShield Service Benefit Plans for 2002.

Benefits not provided under TRICARE are also comparable to the benefits not covered under the FEHBP plans we reviewed. For example, TRICARE does not cover

- over-the-counter contraceptives or over-the-counter pregnancy tests,
- artificial insemination including in vitro fertilization,
- routine genetic testing to determine paternity or child's gender,
- surgery to reverse sterilization, and
- abortion, except when the life of the mother is endangered.¹²

BlueCross BlueShield and Kaiser generally do not cover these services either, although there are limited exceptions. For example, Kaiser covers artificial insemination and in vitro fertilization in certain cases.¹³ While in vitro fertilization services are not covered under the TRICARE benefit, DOD officials told us that these services are offered with a required patient copayment at five MTFs: Keesler Air Force Base, Biloxi, Mississippi; Naval Medical Center, San Diego, California; Walter Reed Army Medical Center, Washington, D.C.; Wilford Hall Medical Center, San Antonio, Texas; and Wright-Patterson Air Force Base, Dayton, Ohio.¹⁴

¹²See 10 U.S.C. § 1093. This statute places the following restrictions on abortions: (a) funds available to DOD may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term and (b) no medical treatment facility or other facility of DOD may be used to perform an abortion except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest.

¹³Kaiser Mid-Atlantic offers in vitro fertilization if (1) the patient and her spouse have a history of infertility of at least 2 years duration as a result of endometriosis, exposure in utero to diethylstilbestrol (commonly known as DES), blockage of, or surgical removal of, one or both fallopian tubes, lateral or bilateral salpingectomy, or abnormal male factors, including oligospermia, contributing to the infertility and (2) the patient has been unable to become pregnant through a less costly infertility treatment for which coverage is available under this plan and (3) the patient's oocytes are fertilized with her spouse's sperm.

¹⁴According to officials at Walter Reed, beneficiaries at their MTF are required to pay a copayment of about \$3,500 to \$5,000 for in vitro fertilization services, while in the civilian sector, the cost would be about \$8,000 to \$10,000. The cost of this service may vary at other MTFs.

In addition, the TRICARE benefit requires some beneficiaries to share in the cost of their health care—a characteristic also found in the FEHBP plans we reviewed. However, the various plan options make direct comparisons difficult. TRICARE Prime enrollees who are active duty members or their family members have no copayments, while Kaiser requires its beneficiaries to pay a \$10 copayment for routine screenings. TRICARE Extra and Standard beneficiaries and BlueCross BlueShield beneficiaries share in the cost of care, with the copayments varying depending on the plan option and the type of provider chosen by the beneficiary.

Most Women Beneficiaries Are Satisfied With DOD's Health Care Benefit, but Some Concerns Exist

Overall, women beneficiaries report being satisfied with the TRICARE health care benefit, but some have concerns about the type of care they receive. Generally, these concerns stem from where beneficiaries are located and their expectations about the types of providers, sources of care, and supplies that should be available. For active duty women, the attitudes of the command personnel can also influence women beneficiaries' satisfaction.

DOD Survey Data Indicate Women Are Generally Satisfied With Health Care Services

According to DOD survey data from 2000, women beneficiaries report being generally satisfied with the TRICARE health benefit and their access to health care services.¹⁵ Results of this survey indicate that women are as satisfied as men with their DOD health plan on four measures pertaining to their experiences with their providers and accessing care. For example, the average rating from women for the health care they received in the last 12 months from all providers was 7.8 on a scale where 10 represents the best health care possible—the same rating as given by men. In addition, 85 percent of women and 87 percent of men reported that they were usually or always satisfied with how well providers communicated. (See table 2.)

¹⁵The Health Care Survey of DOD Beneficiaries is a recurring survey that asks a sample of eligible beneficiaries to comment on their health, the availability of health services, and their level of satisfaction with health services.

Table 2: Women Beneficiaries' Responses to Measures of Satisfaction Compared to Men's

Measure	Women	Men
Average rating of all health care in the last 12 months from all doctors and other health providers (on a scale where 10 represents the best health care possible)	7.8	7.8
Average rating of all experiences with health care plan (on a scale where 10 represents the best health plan possible)	7.3	7.1
Percent who reported that getting needed care was not a problem	68	67
Percent who reported that they were usually or always satisfied with how well doctors and other health care providers communicated	85	87

Source: DOD's Health Care Survey of DOD Beneficiaries for year 2000.

Some Women Beneficiaries Have Concerns About the Available Care

While most of DOD's women beneficiaries are satisfied with the care they receive, some have expressed concerns about their health care. These concerns generally stem from the beneficiary's location—overseas, in remote areas, or in deployed settings—and expectations about the type and source of care available. For active duty women, concerns also stem from the attitudes and the climate established by the command personnel who may not understand women's health care needs.

Some Concerns Are About Care in Overseas, Remote, and Deployed Settings

Military beneficiaries—both men and women—stationed in overseas or remote locations provide a significant challenge for DOD's health system.¹⁶ In locations overseas, DOD supplements its MTF care with civilian host nation care, where medical practice, language, and culture can differ significantly from U.S. civilian care. For example, health care in Japan and Italy is characterized by more inpatient admissions and longer hospital stays than in the U.S. system. In many countries, nurses and administrative staff do not speak English, and the English fluency of doctors varies, making it difficult for patients to discuss their medical problems with host nation personnel. In addition, patients expressed concerns that medical terms might not be translated accurately. Cultural differences have similarly affected beneficiary perceptions of care. For example, in some

¹⁶According to DOD data, over 200,000 active duty members and over 190,000 active duty family members live overseas; and over 160,000 active duty members and over 360,000 active duty family members live in remote areas. DOD defines a "remote" area as one in which an active duty member lives and works more than 50 miles, or about an hour drive, from an MTF.

areas of Europe and the Pacific, doctors are unaccustomed to American patients who may take a more active role in their health care and ask questions about their diagnosis or treatment strategies, procedures, and expected outcomes. As a result, these patients can become frustrated with the more reserved attitude of host nation doctors. Other cultural differences can create a gap in care. For example, in Japan and Korea, patients' families, not nursing staff, typically provide sheets, towels, and toiletries and assist patients during hospitalizations. In 2000, we reported¹⁷ that differences such as these have caused frustrations for some beneficiaries—both men and women—and in some cases have resulted in their delaying care until they can travel to an MTF.

Remote locations—both in the United States and overseas—also present a challenge to DOD in providing care to all of its beneficiaries. In 2000, we reported¹⁸ that, according to DOD, there are some deficiencies in provider availability in rural areas of TRICARE regions in the United States.¹⁹ In remote areas, beneficiaries can have difficulty finding providers, especially for certain types of specialty care, and often have to follow the accepted community access standards, which may require traveling a long distance to obtain care. For example, in some parts of South Dakota, a 2-hour drive is considered routine, and in Alaska, all patients are transported to the lower 48 states for certain types of care. In remote locations overseas, many of DOD's beneficiaries rely on the State Department to provide or help arrange their medical care through a list of local providers who meet U.S. medical standards.²⁰

¹⁷U.S. General Accounting Office, *Defense Health Care: Resources, Patient Access, and Challenges in Europe and the Pacific*, [GAO/HEHS-00-172](#) (Washington, D.C.: Aug. 31, 2000).

¹⁸U.S. General Accounting Office, *Military Health Care: TRICARE's Civilian Provider Networks*, [GAO/HEHS-00-64R](#) (Washington, D.C.: Mar. 13, 2000).

¹⁹To address provider availability deficiencies, in October 1999 DOD implemented TRICARE Prime Remote (TPR) for active duty members stationed in the U.S. who live and work more than 50 miles from an MTF. Eligible active duty members are required to enroll in TPR. TPR enrollees have access to (1) a PCM to manage their health care, authorize specialty care referrals, and file claims, and (2) health care finders—contract staff accessed by toll-free numbers—to help identify primary and specialty care providers and process referrals. DOD plans to expand the program to include family members by September 2002. In the meantime, copayments are waived for family members eligible for TPR.

²⁰[GAO/HEHS-00-172](#).

In deployed settings, such as in the field or on a ship, active duty members may be limited in the choice of health care services and supplies available since DOD tailors the medical capability to the setting and the size of the unit deployed. For women, this constraint has raised concerns about privacy. In 1999, we reported that women deployed to Bosnia described the base camp clinics as very small and lacking interior walls and doors to shield individuals being examined.²¹ These deployed women also had concerns that their medical problems would not be kept confidential by staff at the clinics and that word of their visit would be known around the camp. Deployed women also raised concerns about the availability of supplies, such as feminine hygiene products and birth control pills, in the field or on ships. Due to limited storage space, women may not be able to obtain their preferred brand, but most women were able to obtain adequate supplies. At the end of 2001, DOD officials and representatives from beneficiary groups told us that these concerns remain among deployed women.

Some Concerns About Care Stem From Beneficiary Preferences

According to DOD officials, some women beneficiaries were dissatisfied with the care they received or were reluctant to seek available care because of certain expectations about the type of provider they should see and the setting in which they should receive their care. Several DOD officials told us that some women expressed dissatisfaction or reluctance to seek care from a provider who they perceive to be inexperienced or insensitive to women's issues or who is male. These officials also told us that some women prefer or expect to see a doctor who specializes in obstetrical and gynecological care for their gynecological examinations. This preference or expectation is generally the result of their believing that specialists are better qualified than generalists, such as internists or family practice doctors. According to DOD officials, while obstetrical and gynecological specialists are needed for some procedures, generalists, physician assistants, or nurse practitioners can provide routine care and perform preventive tests. According to beneficiary representatives from DACOWITS and NMFA, women also expressed dissatisfaction with the lack of continuity of care because they did not see the same provider from visit to visit. Finally, DOD officials also said that active duty women noted that they were reluctant to seek care from a provider who is a peer or junior in rank, or is someone with whom they socialize. This can be a

²¹U.S. General Accounting Office, *Gender Issues: Medical Support for Female Soldiers Deployed to Bosnia*, [GAO/NSIAD-99-58](#) (Washington, D.C.: Mar. 10, 1999).

particular problem in some deployed settings where the number of medical staff is limited.

DOD officials also reported that women have preferences for where they receive their maternity care. According to DOD officials, some women prefer to have their babies delivered in civilian hospitals instead of MTFs. Additionally, results from a DOD survey on inpatient care during childbirth at selected MTFs show that some women reported problems with obstetrical care received at MTFs.²² According to survey results from 2000, 26 percent of women beneficiaries reported dissatisfaction with obstetrical care at the MTF, compared to the civilian hospital average of 22 percent. These women reported that their dissatisfaction related to coordination of care, physical comfort, respect for patient preferences, emotional support, involvement of family and friends, and information and education. (See app. II for recent legislation and initiatives by the military branches to address these concerns.)

Commanders and Beneficiaries May Lack Understanding About Women's Health Care Needs

DOD officials told us that reports from the field have indicated that some line commanders, including officers and senior enlisted personnel, may not understand the importance of women's health care. These officials also said in some cases, women beneficiaries also lacked an understanding of their health care needs. Specifically, DOD officials said that some commanders and beneficiaries lack knowledge about women's health issues, the health care services available to women through DOD, when this care should be accessed, and the need for such care. For example, some women beneficiaries do not understand the importance of physical exams and preventive screenings such as Pap smears and mammograms. This can be especially problematic for women—both active duty and family members—who are young and away from their families or other sources of support who might provide health care guidance and teach them the importance of primary and preventive care.²³

In some cases, beneficiaries and commanders have not been adequately trained about the importance of women's basic health care and its effect on readiness. For example, according to DOD officials, neither the Army nor

²²In 2000, DOD conducted a survey to determine beneficiary satisfaction with inpatient care during childbirth at 20 MTFs.

²³The Air Force and the Navy require annual physical exams for all active duty members—men and women. The Army requires annual exams for active duty women, and periodic exams for active duty men, as appropriate (average is every 5 years for men).

the Air Force has a program to train line commanders about women's health care, although the Navy has some efforts to train its leaders about these issues. DOD officials said that, lacking this understanding, some commanders may be reluctant to allow active duty members—both men and women—time away from their duty station to obtain health care services—especially if the commander perceives that their time away will negatively affect the primary mission. For active duty women, explaining their specific ailment to their commanding officer (usually male) or appearing like they need special treatment may make them reluctant to seek the care they need.

Concluding Observations

DOD offers a full range of health care services for women beneficiaries through the TRICARE benefit. In general, TRICARE-covered benefits for women reflect national clinical guidelines developed by ACOG and are comparable to widely used FEHBP health plans. In addition, the TRICARE benefit requires some beneficiaries to share in the cost of their health care—a characteristic also found in the FEHBP plans we reviewed. These copayments vary depending on the plan option and providers selected.

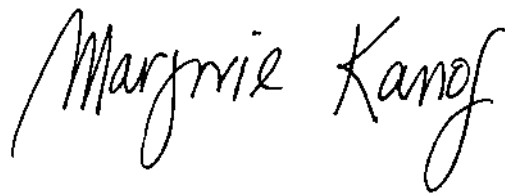
Overall, DOD data indicate that women beneficiaries are satisfied with the TRICARE health care benefit, but some have concerns about the care available to them. Generally, these concerns stem from where the beneficiary is located—overseas, in remote areas, or in deployed settings—and beneficiaries' expectations about the type and source of care that should be available. Concerns can also stem from the attitudes and the climate established by the command personnel. We did not, however, determine the prevalence of any of these concerns. Additionally, we note that some concerns are relevant only to women, but others pertain to men as well.

Agency Comments

We provided DOD a draft of our report for its review. In its comments, DOD agreed with our findings, noting that our portrayal of DOD's health care benefit for women was accurate. DOD also provided technical comments, which we incorporated where appropriate. (DOD's comments appear in app. III.)

We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. We

will also make copies available to others upon request. If you or your staff have questions about this report, please contact me at (202) 512-7101. Other contacts and staff acknowledgments are listed in appendix IV.

A handwritten signature in black ink that reads "Marjorie Kanof". The signature is written in a cursive, flowing style.

Marjorie Kanof
Director, Health Care—Clinical
and Military Health Care Issues

List of Committees

The Honorable Carl Levin
Chairman
The Honorable John Warner
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Bob Stump
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Honorable Daniel Inouye
Chairman
The Honorable Ted Stevens
Ranking Minority Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Jerry Lewis
Chairman
The Honorable John Murtha
Ranking Minority Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Scope and Methodology

Our review focused on issues related to health care provided by the Department of Defense (DOD) that are specific to women, including preventive and reproductive care. To address the key questions, we analyzed pertinent documents (including policies, procedures, and survey results) and interviewed officials from

- DOD's Health Affairs' Office of Clinical and Program Policy,
- DOD's TRICARE Management Activity (TMA),
- the Surgeons General Offices for the Air Force, Army, and Navy, and
- the American College of Obstetricians and Gynecologists (ACOG).

We reviewed selected health care plans under the Federal Employees Health Benefits Program (FEHBP) to compare the covered benefits with those provided by TRICARE. We selected BlueCross and BlueShield Service Benefit Plans, a fee-for-service and preferred provider plan with the largest number of participants in FEHBP, and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., one of the FEHBP's largest health maintenance organization (HMO) plans. In addition, we reviewed completed studies addressing military health care, including those we conducted and those conducted by DOD. We also conducted a site visit to Walter Reed Army Medical Center to review the in vitro fertilization services offered at this military treatment facility (MTF).

To further address these questions, we agreed with the committees of jurisdiction to conduct a high-level review to obtain DOD beneficiaries' perceptions on women's health care services and identify potential concerns about women's health care in DOD. To do this, we interviewed DOD headquarters officials and relied on two DOD surveys: a DOD-wide health care survey on beneficiary satisfaction and a survey targeted at inpatient care during childbirth at selected MTFs. Both of these surveys are from 2000—the most recent data available. We also conducted interviews with

- the Defense Advisory Committee on Women in the Services (DACOWITS), a group that advises the Secretary of Defense on issues concerning active duty women, including health care, and

-
- the National Military Family Association (NMFA), an advocacy group that obtains beneficiary views on issues concerning military families, including health care.

To supplement these interviews, we relied on our past work on DOD health care.

We did not independently validate the information we received from DOD, DACOWITS, or NMFA, nor did we determine the prevalence of beneficiary concerns. Additionally, while our review focused on health care for women beneficiaries, some of our findings pertained to men as well, which we have noted in our report where appropriate. Our work was conducted from November 2001 through April 2002 in accordance with generally accepted government auditing standards.

DOD Policies And Initiatives To Improve Women's Health Care

Over the past decade, DOD has taken a number of steps to improve its women's health care services in response to several factors, such as legislation and beneficiary concerns. Notably, in 1990, DOD added women's health as a responsibility of its Office of Clinical and Program Policy to formulate DOD-wide policy related to women's health issues and to coordinate women's health care activities initiated by the three branches of the military.²⁴ In addition, DOD has established several DOD-wide policies to clarify TRICARE's benefits for women. DOD has also implemented specific initiatives that affect health care provided to women beneficiaries, including maternity care and breast cancer care. Similarly, the three branches of the military have developed initiatives targeted to meet the specific needs of women patients. Many of these efforts aim to better educate leaders and beneficiaries about the importance of women's health care services to readiness.

DOD-wide Policies and Initiatives

Since 1992, DOD has refined and enhanced some of its policies and implemented several initiatives related to women's health care. Many of these efforts were undertaken to respond to findings in the medical community and concerns by the Congress, DACOWITS, and beneficiaries. Key efforts are listed below.

- In 1992, in response to DACOWITS concerns, DOD issued a policy regarding obstetrical care, stating that epidural analgesia would be an option to women for normal vaginal deliveries. According to DOD officials, this policy was based on the medical community's findings that epidural analgesia was the most effective method to control pain during labor and delivery, and allowed for an alert, participating mother.
- In the early 1990s, DOD began to develop and implement the Breast Cancer Initiative to improve early diagnosis, education, and prevention of breast cancer for women beneficiaries. Funds were allocated through the surgeons general of each branch of the military to the local level for beneficiary access to breast cancer screening, diagnosis, and treatment; training of primary care managers; and education programs.

²⁴The Office of Clinical and Program Policy has several program directors assigned to handle different issues. Currently, women's issues are assigned to one program director who is also responsible for mental health issues.

- In 1993, also in response to DACOWITS concerns, DOD established a policy to clarify its standards for (1) access to and timely notification of the results of Pap smears and mammograms and (2) the availability of obstetrical and gynecological appointments for active duty women.
- In 1994, the National Defense Authorization Act (NDAA) authorized DOD to establish a Defense Women's Health Research Center at a selected medical treatment center to coordinate research conducted under DOD, the Department of Health and Human Services, and other federal agencies on women's health issues that are related to military service. The center researches women's health care issues such as the effect on women of exposure to toxins and other environmental hazards; combat stress and trauma; and mental health, including post-traumatic stress disorder and depression.
- In 1995, DOD issued a policy refining the clinical preventive services benefit for all TRICARE Prime enrollees based on the collective expertise of military preventive medicine and to be more consistent with nationally recognized standards for preventive services. These preventive services include the following screenings specific to women: breast cancer (physical exam and mammography); cancer of female reproductive organs (physical exam and Pap smear); Hepatitis B for pregnant women; and counseling about breast self-examination for cancer surveillance.
- In 1998, DOD refined its policy on assigning primary care managers (PCM) to beneficiaries enrolled in TRICARE Prime. PCMs coordinate enrollees' care and refer them to the appropriate specialists, if needed. This policy states that women enrolled in TRICARE Prime shall have the option to choose a PCM who has advanced training in women's health issues.²⁵
- In 2002, NDAA included a provision that will make it easier for TRICARE Standard beneficiaries to obtain civilian maternity care without prior approval from the MTF. DOD is required to implement this provision on the earlier date of either of the following: the date that a new TRICARE Standard contract takes effect or December 28, 2003.

²⁵According to DOD officials, the availability of PCMs with advanced training in women's health care may be limited.

Specific Initiatives by Each Branch of Service

In addition to these DOD-wide efforts, the branches of the military have implemented a number of women's health care initiatives—some of which have been developed by one branch of the service and then adopted by the others. Some of these initiatives aim to improve health care for women, while others focus on providing education to leaders and women beneficiaries to emphasize the importance of women's health to DOD's readiness mission. Other education initiatives focus on the importance of family planning and maternity wellness.

Over the past several years, the Army, Navy, and Air Force have each implemented initiatives aimed at improving health care for their women beneficiaries. For example, in November 2001, all Army MTFs began using liquid-based cytology to read Papanicolaou (Pap) smears which is a faster test than the standard Pap test. According to Army officials, the use of liquid-based cytology will address the readiness concerns identified during the Gulf War. Specifically, women who had received Pap smears in their predeployment screening and were found to have abnormal test results after being deployed were usually returned to Europe or the United States for additional testing or treatment. With the faster test, the Army expects to avoid the cost of returning soldiers from a deployment and the need to back fill these deployments. Both the Navy and the Air Force are also using the liquid-based cytology Pap test in some locations.

The Navy's Perinatal Advisory Board (formerly, the Birth Product Line) has been working to keep deliveries "in house" by improving the birth experience at MTFs. Since its inception in 1997, the board has been assessing patient satisfaction and health care concerns at MTFs worldwide, including why some women choose MTFs and why others choose civilian facilities to deliver their babies. Every Navy MTF worldwide is in the process of implementing "family-centered care" to better coordinate care within the facility and to involve the family in the continuum of care from prenatal through postpartum. The Army and the Air Force have also begun to focus on obstetrical care at their MTFs.

The Air Force also has several other initiatives related to improving women's health care. For example, in 2000, the Air Force began pilot testing "Project Athena" at Aviano Air Force Base in Italy, to provide specialty care in areas—such as obstetrics and gynecology—where it does not have sufficient patient populations to permanently assign several specialists. While Aviano's workload was sufficient to support one obstetrical and gynecological doctor, it was not enough to support two,

although more than one was needed at times. To meet these needs, the Air Force assigned one obstetrical and gynecological specialist full-time, and rotates other specialists to the MTF on temporary assignments—usually 90 days. In addition to providing patients access to specialized care, these rotations have given specialists enough work to keep their skills current. The Air Force has expanded this initiative of rotating obstetrical and gynecological doctors to another location—Misawa Air Force Base in Japan.

Some of the military branches' health care initiatives for women were developed by one branch and then adopted by the others. For example, the Army and the Air Force have developed deployment readiness guides for active duty women and their leaders. The need for such guides was demonstrated in 1999, when we reported²⁶ that 51 percent of women deployed to Bosnia stated that they had not received any information on women-specific health care and hygiene practices in the field prior to deployment. The Army's *Female Soldier Readiness Guide*—which covers areas such as field needs, health care preventive measures in the barracks, and pregnancy—suggests strategies for leaders and soldiers to ensure female readiness. The Air Force's *Female Airman Readiness Guide* is based on the Army's readiness guide and, like the Army guide, aims to enable military leaders to effectively manage women in the Air Force by addressing topics such as hygiene in the field and pregnancy counseling.

Each military branch is also developing systems for tracking women's routine gynecological exams, including Pap smears. Currently, the Air Force reviews the health needs of active duty women and men annually during a preventive health appointment and makes recommendations for further care based on their medical history. For example, during this annual visit, active duty women are told when they are due for their next gynecological exam. In addition, the Army is working on an Army-wide initiative to track active duty women's Pap smears so they can notify them of their annual exams, thereby helping to ensure they receive needed care. This initiative is in the planning stages and has not been implemented, although in the meantime some individual installations have tracking processes in place. Similarly, the Navy has no Navy-wide mechanism for tracking annual exams for women, although there is some tracking of Pap smears at the MTF level.

²⁶[GAO/NSIAD-99-58](#).

Many of the Army's, Navy's, and Air Force's education initiatives aim to educate leaders and beneficiaries about health care services for women, including family planning and pregnancy wellness. According to Army officials, unplanned pregnancies can disrupt work and training situations. Army officials told us various studies show that more than half of births to active duty women in the Army are from unplanned pregnancies. In response, the Army has developed several initiatives to provide beneficiaries with the knowledge to make informed decisions about having children and taking appropriate care measures while pregnant.

- The Center for Health Promotion and Preventive Medicine (CHPPM) is developing a Personal Responsibility Program, including an Army-specific curriculum for soldiers. Its purpose is to provide soldiers with better skills for reducing unplanned pregnancies, including education on reproduction and contraception as well as meshing family planning with career and financial planning. Following pilot testing, this program may be implemented Army-wide.
- The Army's Office of the Deputy Chief of Staff for Personnel convened a multidisciplinary work group that is looking at many aspects of parenthood and its effects on readiness, including unplanned pregnancy and physical training for women after birth. Its intent is to develop a comprehensive reference manual for military leaders to use in managing the myriad issues connected to parenthood.
- CHPPM, with the assistance of a contractor, is developing a certification program for physical training during pregnancy and postpartum. The intent of this program is twofold: to provide Army certification in pregnancy fitness and to provide a safe, standardized program for pregnant and postpartum soldiers. Most women may exercise safely throughout pregnancy within ACOG guidelines and under the advice of their health care provider. Exercise during pregnancy helps prevent unwanted body fat gain and promotes a faster return to physical readiness levels. According to Army officials, one Army study suggested that active duty women who participated in a pregnancy wellness program were more likely to pass the postpartum height/weight requirements than those who did not participate in a structured physical fitness program. In addition, they told us that other studies showed that the caesarian section rate was lower among fitness program participants than the national average, and there were no increases in adverse outcomes to either the pregnant soldiers or their fetuses or infants. They also said that preliminary Army data from the initial pilot

program indicate that there is a beneficial effect on labor and that military readiness is promoted following a regular special exercise program.

The Navy and Air Force have also developed initiatives on family planning and pregnancy wellness. For example, the Navy's Environmental Health Center developed a program called the Sexual Health and Responsibility Program (SHARP) to provide sexual health and responsibility training Navy-wide to both leaders and active duty members through the Internet and CD-ROMs. In addition, the Navy's CHOICES program provides sailors with education on sexually transmitted diseases, pregnancy, relationship building, and sexual responsibility. The goal of the program is to assist sailors in making better choices, which will reduce the number of unplanned pregnancies. CHOICES is available at selected commands, including in San Diego where the Deployment Program Manager of the Fleet Family Services Center has indicated that male and female sailors at Naval Station San Diego, including all shipboard personnel, are required to attend this program. The Navy's recruit training also includes a component on conception and contraception. Specifically, in the seventh week of basic training both females and males attend a program called Recruit Education to Achieve Health (REACH) that includes training on sexual responsibility, family planning, and emergency contraception. The Air Force supports the use of doulas—specially trained women to help other women, particularly first-time mothers, during pregnancy and childbirth—as long as this does not interfere with providing care. A national society of doulas has offered their services free of charge to women beneficiaries. According to Air Force officials, this service could be particularly beneficial to women whose husbands have been deployed.

The branches of the military have provided education on women's health through targeted web sites or a CD-ROM. For example, a Navy website provides information about dysuria, family planning, and emergency contraception. It also provides information on the breast care centers at the National Naval Medical Center in Bethesda and the Naval Medical Centers at San Diego and Portsmouth. The Navy also developed the Operational Obstetrics and Gynecology CD-ROM to serve as a self-contained resource on obstetrical and gynecological care for health care providers of all levels from corpsman through physician providers who are deployed and ashore, stationed away from an MTF or other hospital. According to Navy officials, the fact that it does not require Internet access is crucial during deployment. The CD-ROM is a refresher on the full range of women's health care from Pap smears, family planning, gynecological

Appendix II
DOD Policies And Initiatives To Improve
Women's Health Care

emergencies, and obstetrical care through menopause. It also includes DOD-wide medical instructions pertinent to all three military branches and copies of the female readiness guides for the Army and Air Force. The CD-ROM has been distributed to the Air Force, Army, Coast Guard, and various international military medical forces.

Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

APR 25 2002

Marjorie Kanof, M.D.
Director, Clinical and Military Health Issues
U.S. General Accounting Office
Washington, DC 20548

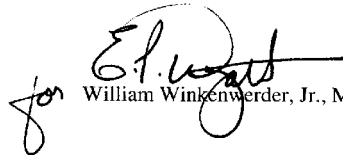
Dear Dr. Kanof:

This is the Department of Defense (DoD) response to the GAO draft report GAO-02-602, "DEFENSE HEALTH CARE: Health Care Benefit for Women Comparable to Other Plans," dated April 12, 2002 (GAO Code 290137).

Overall, DoD finds that the report is an accurate and positive portrayal of the health care benefit for women. In addition, the GAO appropriately identifies the limitations in the report with respect to the reliance on historical reports and inability to validate some of the findings reported by DoD, the Defense Advisory Committee for Women in the Service, or the National Military Family Association.

The Department appreciates the opportunity to comment on the draft report. Please feel free to address any questions to my project officers on this matter, Ms. Patricia Collins, Senior Health Policy Analyst, Operations, (functional) at (703) 681-3900 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Sincerely,


for William Winkenwerder, Jr., MD

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Linda L. Siegel (202) 512-7150

Staff Acknowledgments

Contributors to this report were Ann Calvaresi-Barr, Cynthia D. Forbes, Janice S. Raynor, Mary W. Reich, and Karen Sloan.

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